PATIENT INFORMATION

• KANSAS ORTHOPAEDIC CENTER, P.A.
7550 W. VILLAGE CIRCLE., SUITE 1 • WICHITA, KANSAS 67205

• SURGERY CENTER OF KANSAS
7550 W. • WICHITA, KANSAS 67205

DATE

PATIENT'S NAME (LAST) (FIRST) (MI)			S.S.#	MARITAL STATUS	SEX
STREET ADDRESS			BOX OR APPT.#	BIRTHDATE / AGE	RACE
CITY	STATE	ZIP CODE	HOME PHONE #	WORK PHONE #	
PATIENT'S EMPLOYER / SCHOOL			PATIENT GOES BY/NICKNAME	FULL TIME ☐ PART TIME ☐	
BILLING NAME (LAST) (FIRST) (MI)			S.S.#	OTHER FAMILY MEMBERS PREVIOUSLY TREATED HERE	
INSURED'S EMPLOYER		NPP ACKNOWLEDGEMENT SIGNED?	HOW LONG EMPLOYED?	WORK PHONE #	
PATIENT'S ALTERNATE PHONE #					
PRIMARY CARE PHYSICIAN (GIVE FULL NAME)				PHONE #	
PCP ADDRESS		CITY		STATE / ZIP CODE	
REFERRING PHYSICIAN (GIVE FULL NAME)				PHONE #	
REF. DR. ADDRESS		CITY		STATE / ZIP CODE	
REASON FOR VISIT TODAY (Part(s) of the body)			DATE MEDICAL PROBLEM FIRST NOTICED		
WORKER'S COMP	DATE OF INJURY	WERE YOU INJURED ON THE JOB? ☐ YES ☐ NO ☐ CURRENT JOB ☐ FORMER JOB		HOW	
ACCIDENT/INJURY	DATE OF ACCIDENT	WAS AN AUTOMOBILE INVOLVED? ☐ YES ☐ NO	PLACE OF ACCIDENT (STATE)	HOW	
#1			#2		
#3			#4		
WERE X-RAYS TAKEN OF THIS INJURY OR PROBLEM? ☐ YES ☐ NO	IF YES, WHERE TAKEN (HOSPITAL, ETC.)			DATE X-RAYS TAKEN	

INSURANCE SET INFORMATION

1) Health

2) W/C

3) Auto

4) Liability

5) Other

6) Auto Maxed

IMPORTANT: *PLEASE READ THE INFORMATION ON THE BACK OF THIS SHEET, YOUR SIGNATURE REQUIRED.*

KANSAS ORTHOPAEDIC CENTER, P.A.

PLEASE READ

As part of your care, the physician may suggest referral to Surgery Center of Kansas or Kansas Spine Hospital. We want you to know that some of the physicians have an investment interest in these facilities. Should you wish, you may obtain surgery or services elsewhere. We believe, however that our investment and supervision of these facilities assures you the finest, most responsive care available.

Payment is due at the time of service. While the office submits insurance, the patient remains responsible and must furnish accurate insurance information.

All services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees (subject to carrier contractual arrangements), regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our patient representatives.

INSURANCE AUTHORIZATION AND ASSIGNMENT; TREATMENT AUTHORIZATION; AUTHORIZATION TO RELEASE INFORMATION

I request that payment of authorized Medicare/Other insurance company benefits be made either to me or on my behalf to the above named provider(s) for any services furnished me by that provider(s). I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable to related services. If my care is covered by Workers' Compensation, I authorize release of medical information to my employer and/or case manager. I authorize the above named groups to release any medical information necessary to my insurance company.

I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If item 9 of the CMS-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/Other INsurance company assigned cases, provider(s) agrees to accept the charge determination of the Medicare/Other insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other insurance company.

In the event that a health care worker is suspected to have been exposed to my blood or body fluids or in the event that my illness requires such care that health care worker exposure to my blood and body fluids is likely, I consent to have the above provider(s) determine by serological testing whether or not my blood contained contagious viruses. I understand the information obtained from such tests will only be exposed as necessary to adequately protect my own health and the health of my family as well as the health care personnel who may become involved in my treatment, except as otherwise required by law. (see KSA 65-6002 (a).

I hearby consent to treatment by the above provider(s) and certify that no guarantee/assurance has been made regarding results.

SIGNATURE_____ DATE_____

ATTENTION MEDICARE PATIENTS ONLY

(TO BE COMPLETED FOR ALL MEDICARE PATIENTS)

MEDICARE SECONDARY PAYER QUESTIONNAIRE

NAME_____ **DATE OF SERVICE**_____

(If any answer to questions 1a. through 5. is YES, the corresponding section of the "Other Insurance" form must be filled out completely.)

		YES	NO
1.	Is the patient a Veteran?	☐	☐
	a. Did the VA refer you here for treatment?	☐	☐
	b. Does the patient have a VA "fee basis ID Card?"	☐	☐
2.	Do you have a Federal Black Lung card?	☐	☐
3.	Is this medical condition due to an accident of any kind?	☐	☐
	If yes, was it: ☐ Work Related ☐ Auto ☐ Injured in own home ☐ Other		
4.	Is the patient covered by a health insurance plan through their own current employment or that of a family member (Not retiree coverage?)	☐	☐
5.	Is the patient currently in a Skilled Nursing Facility	☐	☐

If yes, Facility Name: _____ Phone #: _____

Address: _____

ONE TIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the above named groups for any services furnished me by that physician(s). I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Service (CMS) and its agents any information needed to determine these benefits for the benefits payable for related services.

PATIENT'S SIGNATURE_____ **DATE SIGNED**_____

PATIENT HEALTH HISTORY

DATE

PATIENT NAME (LAST) (FIRST) (MI) | BIRTHDATE | AGE | SEX ☐ M ☐ F | ☐ RIGHT HANDED ☐ LEFT HANDED

OCCUPATION | MARITAL STATUS ☐ S ☐ M ☐ W ☐ D ☐ SEP | PHONE #

REFERRING PHYSICIAN

REASON FOR TODAY'S VISIT

DRUG ALLERGIES & REACTION TO DRUGS: (REACTION. E.G., HIVES, RASH, ETC.)

Y N — LATEX ALLERGY ❑ ❑ — METAL ALLERGY ❑ ❑

SLEEP APNEA ❑ ❑ — 02/CPAP USER ❑ ❑

CURRENT MEDICATIONS: (IF INSULIN DEPENDENT DIABETIC - LIST TYPE OF INSULIN. UNITS TAKEN & TIMES OF DAY)

MEDICINE NAME	DOSE	FREQUENCY	MEDICINE NAME	DOSE	FREQUENCY
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

TESTS DONE WITHIN LAST SIX MONTHS

	YES	NO	WHERE DONE	COMMENTS
BLOOD WORKUP / CBC				
MRI				
X-RAY DONE (KIND)				
COMPLETE PHYSICAL				
EKG				
TREADMILL TEST				
OTHER				

PREVIOUS OPERATIONS

	YES	NO	DATE		YES	NO	DATE	RIGHT	LEFT
TONSILLECTOMY				CARPAL TUNNEL RELEASE					
APPENDECTOMY				SHOULDER					
GALLBLADDER				HIP					
HYSTERECTOMY				KNEE					
BACK				OTHER					

CORONARY ARTERY BYPASS SURGERY ☐ Yes ☐ No Date _____ Number of Grafts _____ Hospital _____

HAVE YOU OR ANY FAMILY MEMBER EVER HAD ANY PROBLEM WITH ANESTHESIA? ☐ YES ☐ NO (If Yes) please explain _____

HOSPITALIZATIONS (OTHER THAN ABOVE)

DESCRIPTION OF ILLNESS / REASON	YEAR	HOSPITAL

Please give any other insights and/or information that you feel might be helpful in your care and/or health maintenance.

COMPLETE FRONT AND BACK OF THIS FORM

OFFICE USE ONLY

TODAY'S DATE | SURGERY DATE

DOCTOR

PROCEDURE

❑ SCK ❑ SFRMC ❑ SJMC ❑ WMC ❑ KSH

OTHER _____

TESTS ORDERED

	YES	NO
EKG	❑	❑
CHEST XRAY	❑	❑
LAB	❑	❑
AIRWAY EVAL	❑	❑

VITAL SIGNS

B/P	PULSE	RESP	DATE OBTAINED
			REVIEWED DATE
HGT	WGT	A/O	REVIEWED DATE

ASSESSMENT OBTAINED & REVIEWED BY: (MA SIGNATURE)

ASSESSMENT OBTAINED & REVIEWED BY: (PA/DR SIGNATURE)

MEDICAL HISTORY

HISTORY OF	PERSONAL		
	YES	NO	DETAILS OF YES ANSWER
PACEMAKER			
HEART ATTACK			
CHEST PAIN			
HEART MURMUR			
HEART PALPITATION			
IRREGULAR HEART BEAT			
CONGESTIVE HEART FAILURE			
ENLARGED HEART			
SHORTNESS OF BREATH			
HIGH BLOOD PRESSURE			
LOW BLOOD PRESSURE			
HEADACHE			
STROKE			
SCARLET FEVER			
RHEUMATIC FEVER			
FAINTING			
PHLEBITIS / BLOOD CLOTS			
OTHER CARDIAC / HEART PROBLEMS			
ASTHMA / EMPHYSEMA			
BRONCHITIS			
COUGH / CHRONIC - OR IN A.M.			
LUNG DISEASE			
TUBERCULOSIS			
PLEURISY			
PNEUMONIA			
SINUSITIS			
ARTHRITIS			
BACK DISORDERS			
DEGENERATIVEJOINT DISEASE			
SWOLLEN / PAINFUL JOINTS			
DIABETES / HYPOGLYCEMIA			
THYRIOD DISORDER			
SEIZURES			
KIDNEY DIALYSIS			
KIDNEY INFECTION / BLADDER PROBLEMS			
CANCER			
LEUKEMIA			
LUPUS DISEASE			
SICKLE CELL			
HITAL HERNIA			
STOMACH / BOWEL PROBLEMS			
ULCER			
GLAUCOMA			
HEPATITIS			
CIRRHOSIS OF LIVER			
HIV / AIDS			
WOUND HEALING PROBLEMS			
PSYCHIATRIC HISTORY			
OTHER			

OFFICE USE ONLY

FAMILY HISTORY

+	−		+	−	
		CARDIOVASCULAR			RESPIRATORY/SMOKER
		DIABETIC			SEIZURES
		ANEMIA/BLEEDING			GI
		CANCER			GU
		HEPATITIS			GLAUCOMA

If yes, see Medical Hx.

PHYSICAL EXAM

N = NORMAL AB = ABNORMAL, FURTHER COMMENTS

ALERT & ORIENTED: X3 ( ) OTHER ( )_____

HEENT: _____

HEART: _____

LUNGS: _____

ABDOMEN: _____

EXTREMITES: _____

EXAM SPECIFIC: AFFECTED AREA LT. RT.

EXAM PERTINENT TO MEDICAL CONDITIONS:

SOCIAL HISTORY

SMOKE	☐ YES_____PPD		☐ NEVER	☐ FORMER
ALCOHOL	☐ NEVER	☐ RARELY	☐ SOCIALLY	☐ DAILY
RECREATIONAL DRUGS	☐ NEVER	☐ RARELY	☐ SOCIALLY	☐ DAILY

PATIENT'S SIGNATURE

DATE SIGNED